

CONNECTICUT VALLEY HOSPITAL OPERATIONAL PROCEDURE MANUAL

SECTION I:	PATIENT FOCUSED FUNCTIONS
CHAPTER 2:	Provision of Care, Treatment and Services
PROCEDURE 2.16:	Documentation of Patient Progress and Care
REVISED:	09/27/07; 02/08/08; 05/24/10; 09/14/15; 11/14/16; 02/18, 03/19; 4/5/19
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PURPOSE: To describe a process for documenting patient progress in achieving goals and objectives, the recognition and evaluation of significant changes in the patient's behavior or clinical condition, and communicating to other clinicians and care providers engaged in the treatment of the patient.

SCOPE: All Clinical Staff

POLICY:

The Integrated Treatment Plan delineates patient specific treatment goals, objectives, and interventions. Progress notes recorded by the professional staff or others responsible for the patient's treatment, give a chronological picture of the patient's progress or lack of progress towards attaining goals and objectives as outlined in the patient's integrated treatment plan.

PROCEDURE:

I. Time Frame(s) for Completion of Progress Notes

Progress Notes-Psychiatry – ASD	3 X wk. for 2 wks. Then 2 x wk.
GPD	QW for 60 Days Then QM + Incidentals
Progress Notes - ACS Clinicians	Monthly Note within one month of admission Then Bimonthly Notes (every two months) + Incidentals
Progress Notes - Nursing Staff Admission	QD X 1 wk.> Then QW up to 60 days + Incidental. Then QM + Incidentals
Progress Notes - Nursing Staff Transfer	QD X 1 wk.> Then QW for 30 days + Incidental Then QM + Incidentals
Progress Notes - SW	QW for 60 Days Then QM + Program/Session Notes
Progress Notes - Rehab	QW and/or Program/Session Notes for 60 Days then Program/Session Notes
Progress Note – Psychology	QM + Program/Session Notes

II. General Content of Weekly/Monthly Progress Notes for all Disciplines

- A. Progress Notes are written to document the individual's response and perspective to specific treatment interventions, to communicate special instructions or results or to communicate any changes in the patient's condition or life situation; legal or discharge indications or to address specific issues or concerns. A combined Treatment (session) Note and Progress Note may be written for Rehabilitation Services.
- B. Treatment providers should document per discipline-specific guidelines located in their discipline manual or the HIM manual.
- C. Incidental Progress Notes, (such as daily observation notes), do not fulfill the requirement for Nursing Progress Notes as outlined above.
- D. Specific requirements for more detailed information or more frequent documentation by Physicians in ASD, Registered Nurses, Licensed Practical Nurses, Mental Health Assistants apply. For specific reference refer to [HIM Procedure 2.15](#) and [Nursing Policy & Procedure 7.5 Integrated Progress Notes](#).

III. Progress Notes for Individual or Group Interventions

- A. A progress note should be completed after each Individual or Group Intervention. The note should minimally describe the content of the discussion, the patient's specific participation objectives, and the progress made towards those objectives during the intervention. These notes can either be hand written in the chart or entered using the RMS Group/Individual Service Note.
- B. RMS Summary Service Notes can only be filed (either electronically or in hard copy) to fulfill this documentation requirement if they contain all of the elements specified above for each group or individual session that occurred during the summary period.
- C. Treatment (session) Notes and Progress Notes may be combined for Rehabilitation Services.

IV. Weekly/Monthly Progress Notes:

- A. Regular entries entered, (per the schedule defined in Section I), by disciplines document a patient's progress towards achieving specific treatment objectives. Such notes summarize each treatment intervention employed, the patient's response to the treatment, and provide suggestions to improve upon the treatment being provided.
- B. As noted above some disciplines have defined specific format and content requirements for progress notes.

V. Patients on Temporary Leave, Leave of Absence, or Elopement Status:

If a monthly or weekly Progress Note comes due while a patient is on LOA or is

AWOL, a note is written by the psychiatrist, the nurse, and the social worker.

VI. Incidental Progress Notes:

- A. Incidental Progress Notes contain information about specific events or time period observations related to the patient in recovery. The content is specific to the reason the note is generated, but should refer to relevant treatment objectives. This category includes the following types of notes:
1. Observation Notes-describe specific behaviors and staff interventions for patients on increased levels of observation.
 2. Change in intervention: change in medication, change in observation level or privilege level, consultation ordered, labs or imaging ordered, change in the routine frequency the pt. will be seen, etc.
 3. Change of Condition Notes-describe significant changes in behavior or condition such as trauma, refusal of treatment, level on hold, restraint or seclusion, medication changes, assaults, suicidal attempts, ideation or self-abusive behaviors, the need for a STAT or PRN medication.
 4. Appointment Notes-describe attendance and/or participation by the patient in specific appointments such as medical/dental treatment(s), legal proceeding(s), or advocate meeting(s).
 5. *“On Service” and “Off Service” Progress Note:*

When a staff member is (permanently) re-assigned to a Treatment Team, an "on service" note is written in the Progress Note section by the new staff member, noting the staffing change or reassignment and how it will impact the patient and the implementation of the MTP. Conversely an “Off service” note is written when a staff member is removed from a Treatment Team.

VII. Transfer Progress Notes: (See [HIM Procedure 2.16](#))

- A. The sending unit documents summary of course treatment in the progress note section.
- B. The receiving unit documents hand-off communication and initial adjustments onto units.

VIII. Discharge Progress Notes:

- A. Patient's Discharged Against Medical Advice (AMA), Against Clinical Advice (ACA), or for Non-Compliance with Rules - Addiction Services Division ONLY.
- B. The Psychiatrist, ACS Clinician/On-Call Physician discharging a patient either AMA, ACA or for Non-Compliance with Rules, must record the reason that the patient is leaving the ASD under these conditions in the Progress Note section of the chart.

IX. Patients on MD/AC Status:

- A. Ambulatory Care Services (ACS) Clinician/On-call Physician Progress Note for Medical Discharge to Acute Care Hospital (MD/AC) or Admission From MD/AC

(See also [*HIM Policy 3.1*](#)):

1. The ACS clinician or on-call physician writes a note in the chart, which describes why the patient was discharged to MD/AC and the condition of the patient.
2. The ACS clinician or on-call physician writes a note in the chart when the patient is admitted from MD/AC to CVH, which describes the events of the general hospitalization, the condition of the patient on admission, and an initial treatment plan.
3. If a monthly or weekly Progress Note comes due while a patient is MD/AC status, a note is written by the psychiatrist, the nurse, and the social worker.